General

Guideline Title

U.S. selected practice recommendations for contraceptive use, 2013: adapted from the World Health Organization selected practice recommendations for contraceptive use, 2nd edition.

Bibliographic Source(s)

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Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

How to Use This Document

The recommendations in this report are intended to help health-care providers address issues related to use of contraceptives, such as how to help a woman initiate use of a contraceptive method, which examinations and tests are needed before initiating use of a contraceptive method, what regular follow-up is needed, and how to address problems that often arise during use, including missed pills and side effects such as unscheduled bleeding. Each recommendation addresses what a woman or health-care provider can do in specific situations. For situations in which certain groups of women might be medically ineligible to follow the recommendations, comments and reference to U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 (U.S. MEC) are provided. The full U.S. MEC recommendations and the evidence supporting those recommendations were published in 2010.

The information is organized by contraceptive method, and the methods generally are presented in order of effectiveness, from highest to lowest. However, the recommendations are not intended to provide guidance on every aspect of provision and management of contraceptive method use. Instead, they use the best available evidence to address specific issues regarding common, yet sometimes complex, clinical issues. Each contraceptive method section generally includes information about initiation of the method, regular follow-up, and management of problems with use (e.g., usage errors and side effects). Each section first provides the recommendation and then includes a comments and evidence section, which includes comments about the recommendations and a brief summary of the scientific evidence on which the recommendation is based (refer to the original guideline document for comments and evidence).

Recommendations are provided for permanent methods of contraception, such as vasectomy and female sterilization, as well as for reversible

methods of contraception, including the copper-containing intrauterine device (Cu-IUD); levonorgestrel-releasing IUD (LNG-IUD); the etonogestrel implant; progestin-only injectables; progestin-only pills (POPs); combined hormonal contraceptive methods that contain both estrogen and a progestin, including combined oral contraceptives (COCs), a transdermal contraceptive patch, and a vaginal contraceptive ring; and the standard days method (SDM). Recommendations also are provided for emergency use of the Cu-IUD and emergency contraceptive pills (ECPs).

For each contraceptive method, recommendations are provided on the timing for initiation of the method and indications for when and for how long additional contraception, or a back-up method, is needed. Many of these recommendations include guidance that a woman can start a contraceptive method at any time during her menstrual cycle if it is reasonably certain that the woman is not pregnant. Guidance for health-care providers on how to be reasonably certain that a woman is not pregnant is provided.

For each contraceptive method, recommendations include the examinations and tests needed before initiation of the method. These recommendations apply to persons who are presumed to be healthy. Those with known medical problems or other special conditions might need additional examinations or tests before being determined to be appropriate candidates for a particular method of contraception. U.S. MEC might be useful in such circumstances. Most women need no or very few examinations or tests before initiating a contraceptive method.

Summary charts and clinical algorithms that summarize the guidance for the various contraceptive methods have been developed for many of the recommendations, including when to start using specific contraceptive methods (see Appendix B in the original guideline document), examinations and tests needed before initiating the various contraceptive methods see (Appendix C in the original guideline document), routine follow-up after initiating contraception (see Appendix D in the original guideline document), management of bleeding irregularities (see Appendix E in the original guideline document), and management of IUDs when users are found to have pelvic inflammatory disease (PID) (see Appendix F in the original guideline document). These summaries might be helpful to health-care providers when managing family planning patients. Additional tools are available on the U.S. Selected Practice Recommendations (SPR) Web site .

Summary of Changes from World Health Organization (WHO) SPR

Much of the guidance in the Centers for Disease Control and Prevention (CDC) U.S. Selected Practice Recommendations for Contraceptive Use 2013 (U.S. SPR) is the same or very similar to the WHO SPR guidance. U.S. SPR includes new guidance on the use of the combined contraceptive patch and vaginal ring, as well as recommendations for four new topics:

- How to start regular contraception after taking ECPs
- Management of bleeding irregularities among women using extended or continuous combined hormonal contraceptives (including pills, the patch, and the ring)
- When a woman can rely on female sterilization for contraception
- When a woman can stop using contraceptives and not be at risk for unintended pregnancy

Adaptations to the WHO SPR recommendations include 1) changes to the length of the grace period for depot medroxyprogesterone acetate (DMPA) reinjection, 2) differences in some of the examinations and tests recommended before contraceptive method initiation, 3) differences in some of the recommendations for management of bleeding irregularities because of new data and drug availability in the United States, and 4) a modified missed pill algorithm to respond to concerns of the CDC expert group and other reviewers that simplified algorithms are preferable.

Contraceptive Method Choice

Many elements need to be considered individually by a woman, man, or couple when choosing the most appropriate contraceptive method. Some of these elements include safety, effectiveness, availability (including accessibility and affordability), and acceptability.

Contraceptive method effectiveness is critically important in minimizing the risk for unintended pregnancy, particularly among women for whom an unintended pregnancy would pose additional health risks. The effectiveness of contraceptive methods depends both on the inherent effectiveness of the method itself and on how consistently and correctly it is used (see Table 1 in the original guideline document). Both consistent and correct use can vary greatly with characteristics such as age, income, desire to prevent or delay pregnancy, and culture. Methods that depend on consistent and correct use by clients have a wide range of effectiveness between typical and perfect users. IUDs and implants are considered long-acting, reversible contraception (LARC); these methods are highly effective because they do not depend on regular compliance from the user. LARC methods are appropriate for most women, including adolescents and nulliparous women. All women should be counseled about the full range and effectiveness of contraceptive options for which they are medically eligible so that they can identify the optimal method (see Figure 1 in the original guideline document).

In choosing a method of contraception, the risk for human immunodeficiency virus (HIV) infection and other sexually transmitted diseases (STDs) also should be considered. Although hormonal contraceptives and IUDs are highly effective at preventing pregnancy, they do not protect against STDs and HIV. Consistent and correct use of the male latex condom reduces the risk for HIV infection and other STDs, including chlamydial

infection, gonorrhea, and trichomoniasis. On the basis of a limited number of clinical studies, when a male condom cannot be used properly to prevent infection, a female condom should be considered. All patients, regardless of contraceptive choice, should be counseled about the use of condoms and the risk for STDs, including HIV infection. Additional information about prevention and treatment of STDs is available from the CDC *Sexually Transmitted Diseases Treatment Guidelines*.

How to Be Reasonably Certain That a Woman Is Not Pregnant

In most cases, a detailed history provides the most accurate assessment of pregnancy risk in a woman who is about to start using a contraceptive method. Several criteria for assessing pregnancy risk are listed in the recommendation that follows. These criteria are highly accurate (i.e., a negative predictive value of 99%–100%) in ruling out pregnancy among women who are not pregnant. Therefore, CDC recommends that health-care providers use these criteria to assess pregnancy status in a woman who is about to start using contraceptives (see Box 1 below). If a woman meets one of these criteria (and therefore the health-care provider can be reasonably certain that she is not pregnant), a urine pregnancy test might be considered in addition to these criteria (based on clinical judgment), bearing in mind the limitations of the accuracy of pregnancy testing. If a woman does not meet any of these criteria, then the health-care provider cannot be reasonably certain that she is not pregnant, even with a negative pregnancy test. Routine pregnancy testing for every woman is not necessary.

On the basis of clinical judgment, health-care providers might consider the addition of a urine pregnancy test; however, they should be aware of the limitations, including accuracy of the test relative to the time of last sexual intercourse, recent delivery, or spontaneous or induced abortion. Routine pregnancy testing for every woman is not necessary. If a woman has had recent (i.e., within the last 5 days) unprotected sexual intercourse, consider offering emergency contraception (either a Cu-IUD or ECPs), if pregnancy is not desired.

Box 1. How to Be Reasonably Certain That a Woman Is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- Is ≤7 days after the start of normal menses
- Has not had sexual intercourse since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is ≤7 days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds),* amenorrheic, and <6 months postpartum

Source: Labbok M, Perez A, Valdez V, et al. The Lactational Amenorrhea Method (LAM): a postpartum introductory family planning method with policy and program implications. Adv Contracept 1994;10:93–109.

Intrauterine Contraception

Three IUDs are available in the United States, the Cu-IUD and two LNG-IUDs (containing a total of either 13.5 mg or 52 mg levonorgestrel). Fewer than 1 woman out of 100 becomes pregnant in the first year of using IUDs (with typical use). IUDs are long acting, are reversible, and can be used by women of all ages, including adolescents, and both by parous and nulliparous women. IUDs do not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, HIV.

Initiation of Cu-IUDs

Timing

- The Cu-IUD can be inserted at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- The Cu-IUD also can be inserted within 5 days of the first act of unprotected sexual intercourse as an emergency contraceptive. If the day of ovulation can be estimated, the Cu-IUD also can be inserted >5 days after sexual intercourse as long as insertion does not occur >5 days after ovulation.

Need for Back-Up Contraception

- No additional contraceptive protection is needed after Cu-IUD insertion.

Special Considerations

Amenorrhea (Not Postpartum)

- Timing: The Cu-IUD can be inserted at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: No additional contraceptive protection is needed.

Postpartum (Including after Cesarean Section)

- Timing: The Cu-IUD can be inserted at any time postpartum, including immediately postpartum (U.S. MEC 1 or 2) (see Box 2 below for definitions), if it is reasonably certain that the woman is not pregnant (see Box 1 above). The Cu-IUD should not be inserted in a woman with puerperal sepsis (U.S. MEC 4).
- Need for back-up contraception: No additional contraceptive protection is needed.

Postabortion (Spontaneous or Induced)

- Timing: The Cu-IUD can be inserted within the first 7 days, including immediately postabortion (U.S. MEC 1 for first trimester abortion and U.S. MEC 2 for second trimester abortion). The Cu-IUD should not be inserted immediately after septic abortion (U.S. MEC 4).
- Need for back-up contraception: No additional contraceptive protection is needed.

Switching from Another Contraceptive Method

- Timing: The Cu-IUD can be inserted immediately if it is reasonably certain that the woman is not pregnant (see Box 1 above). Waiting for her next menstrual period is unnecessary.
- Need for back-up contraception: No additional contraceptive protection is needed.

Box 2. Categories of Medical Eligibility Criteria for Contraceptive Use

U.S. MEC 1 = A condition for which there is no restriction for the use of the contraceptive method. U.S. MEC 2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks. U.S. MEC 3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method. U.S. MEC 4 = A condition that represents an unacceptable health risk if the contraceptive method is used.
Abbreviations: U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use*, 2010. Source: CDC. U.S. medical eligibility criteria for contraceptive use. *MMWR* 2010;59 (No. RR-4).

Initiation of LNG-IUDs

Timing of LNG-IUD Insertion

- The LNG-IUD can be inserted at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).

Need for Back-Up Contraception

- If the LNG-IUD is inserted within the first 7 days since menstrual bleeding started, no additional contraceptive protection is needed.
- If the LNG-IUD is inserted >7 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Special Considerations

Amenorrhea (Not Postpartum)

- Timing: The LNG-IUD can be inserted at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (Including after Cesarean Section)

- Timing: The LNG-IUD can be inserted at any time, including immediately postpartum (U.S. MEC 1 or 2) if it is reasonably certain that the woman is not pregnant (see Box 1 above). The LNG-IUD should not be inserted in a woman with puerperal sepsis (U.S. MEC 4).
- Need for back-up contraception: If the woman is <6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), no additional contraceptive protection is needed. Otherwise, a woman who is ≥21 days postpartum and has not experienced return of her menstrual cycle needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. If her menstrual cycles have returned and it has been >7 days since menstrual bleeding began, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postabortion (Spontaneous or Induced)

- Timing: The LNG-IUD can be inserted within the first 7 days, including immediately postabortion (U.S. MEC 1 for first-trimester abortion and U.S. MEC 2 for second trimester abortion). The LNG-IUD should not be inserted immediately after a septic abortion (U.S. MEC 4).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days unless the IUD is placed at the time of a surgical abortion.

Switching from Another Contraceptive Method

- Timing: The LNG-IUD can be inserted immediately if it is reasonably certain that the woman is not pregnant (see Box 1 above). Waiting for her next menstrual period is unnecessary.
- Need for back-up contraception: If it has been >7 days since menstrual bleeding began, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
- Switching from a Cu-IUD: If the woman has had sexual intercourse since the start of her current menstrual cycle and it has been >5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A health-care provider can consider providing ECPs at the time of LNG-IUD insertion.

Examinations and Tests Needed before Initiation of a Cu-IUD or an LNG-IUD

Among healthy women, few examinations or tests are needed before initiation of an IUD (see Table 2 in the original guideline document). Bimanual examination and cervical inspection are necessary before IUD insertion. A baseline weight and body mass index (BMI) measurement might be useful for monitoring IUD users over time. If a woman has not been screened for STDs according to STD screening guidelines, screening can be performed at the time of insertion. Women with known medical problems or other special conditions might need additional examinations or tests before being determined to be appropriate candidates for a particular method of contraception. U.S. MEC might be useful in such circumstances.

Provision of Prophylactic Antibiotics at the Time of IUD Insertion

- Prophylactic antibiotics are generally not recommended for Cu-IUD or LNG-IUD insertion.

Routine Follow-Up after IUD Insertion

These recommendations address when routine follow-up is needed for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, persons with certain medical conditions or characteristics, and persons with multiple medical conditions.

- Advise a woman to return at any time to discuss side effects or other problems, if she wants to change the method being used, and when it is time to remove or replace the contraceptive method. No routine follow-up visit is required.
- At other routine visits, health-care providers who see IUD users should do the following:
    - Assess the woman's satisfaction with her contraceptive method and whether she has any concerns about method use.
    - Assess any changes in health status, including medications, that would change the appropriateness of the IUD for safe and effective continued use on the basis of U.S. MEC (e.g., category 3 and 4 conditions and characteristics).
    - Consider performing an examination to check for the presence of the IUD strings.
    - Consider assessing weight changes and counseling women who are concerned about weight changes perceived to be associated with their contraceptive method.

Bleeding Irregularities with Cu-IUD Use

- Before Cu-IUD insertion, provide counseling about potential changes in bleeding patterns during Cu-IUD use. Unscheduled spotting or light

bleeding, as well as heavy or prolonged bleeding, is common during the first 3 to 6 months of Cu-IUD use, is generally not harmful, and decreases with continued Cu-IUD use.

- If clinically indicated, consider an underlying gynecological problem, such as Cu-IUD displacement, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids), especially in women who have already been using the Cu-IUD for a few months or longer and who have developed a new onset of heavy or prolonged bleeding. If an underlying gynecological problem is found, treat the condition or refer for care.
- If an underlying gynecological problem is not found and the woman requests treatment, the following treatment option can be considered during days of bleeding:
    - Nonsteroidal anti-inflammatory drugs (NSAIDs) for short-term treatment (5–7 days)
- If bleeding persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Bleeding Irregularities (Including Amenorrhea) with LNG-IUD Use

Before LNG-IUD insertion, provide counseling about potential changes in bleeding patterns during LNG-IUD use. Unscheduled spotting or light bleeding is expected during the first 3 to 6 months of LNG-IUD use, is generally not harmful, and decreases with continued LNG-IUD use. Over time, bleeding generally decreases with LNG-IUD use, and many women experience only light menstrual bleeding or amenorrhea. Heavy or prolonged bleeding, either unscheduled or menstrual, is uncommon during LNG-IUD use.

Irregular Bleeding (Spotting, Light Bleeding, or Heavy or Prolonged Bleeding)

- If clinically indicated, consider an underlying gynecological problem, such as LNG-IUD displacement, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids). If an underlying gynecological problem is found, treat the condition or refer for care.
- If bleeding persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Amenorrhea

- Amenorrhea does not require any medical treatment. Provide reassurance.
    - If a woman's regular bleeding pattern changes abruptly to amenorrhea, consider ruling out pregnancy if clinically indicated.
- If amenorrhea persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Management of the IUD When a Cu-IUD or an LNG-IUD User Is Found to Have Pelvic Inflammatory Disease (PID)

- Treat the PID according to the CDC guideline Pelvic inflammatory disease. In: Sexually transmitted diseases treatment guidelines, 2010.
- Provide comprehensive management for STDs, including counseling about condom use.
- The IUD does not need to be removed immediately if the woman needs ongoing contraception.
- Reassess the woman in 48 to 72 hours. If no clinical improvement occurs, continue antibiotics and consider removal of the IUD.
- If the woman wants to discontinue use, remove the IUD sometime after antibiotics have been started to avoid the potential risk for bacterial spread resulting from the removal procedure.
- If the IUD is removed, consider ECPs if appropriate. Counsel the woman on alternative contraceptive methods, and offer another method if it is desired.
- A summary of IUD management in women with PID is provided (see Appendix F in the original guideline document).

Management of the IUD When a Cu-IUD or an LNG-IUD User Is Found to Be Pregnant

- Evaluate for possible ectopic pregnancy.
- Advise the woman that she has an increased risk for spontaneous abortion (including septic abortion that might be life threatening) and of preterm delivery if the IUD is left in place. The removal of the IUD reduces these risks but might not decrease the risk to the baseline level of a pregnancy without an IUD.
    - If she does not want to continue the pregnancy, counsel her about options.
    - If she wants continue the pregnancy, advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

IUD Strings Are Visible or Can Be Retrieved Safely from the Cervical Canal

- Advise the woman that the IUD should be removed as soon as possible.

    - If the IUD is to be removed, remove it by pulling on the strings gently.
    - Advise the woman that she should return promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.
- If she chooses to keep the IUD, advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

IUD Strings Are Not Visible and Cannot Be Retrieved Safely

- If ultrasonography is available, consider performing or referring for ultrasound examination to determine the location of the IUD. If the IUD cannot be located, it might have been expelled or have perforated the uterine wall.
- If ultrasonography is not possible or the IUD is determined by ultrasound to be inside the uterus, advise the woman to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

Implants

The etonogestrel implant, a single rod with 68 mg of etonogestrel, is available in the United States. Fewer than 1 woman out of 100 become pregnant in the first year of use of the etonogestrel implant with typical use. The implant is long acting, is reversible, and can be used by women of all ages, including adolescents. The implant does not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, including HIV.

Initiation of Implants

Timing

- The implant can be inserted at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).

Need for Back-Up Contraception

- If the implant is inserted within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
- If the implant is inserted >5 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Special Considerations

Amenorrhea (Not Postpartum)

- Timing: The implant can be inserted at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (Breastfeeding)

- Timing: The implant can be inserted at any time (U.S. MEC 2 if <1 month postpartum and U.S. MEC 1 if ≥1 month postpartum) if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: If the woman is <6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), no additional contraceptive protection is needed. Otherwise, a woman who is ≥21 days postpartum and has not experienced return of her menstrual cycle needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. If her menstrual cycles have returned and it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (Not Breastfeeding)

- Timing: The implant can be inserted at any time, including immediately postpartum (U.S. MEC 1) if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: A woman who is ≥21 days postpartum and has not experienced return of her menstrual cycle needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. If her menstrual cycles have returned and it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postabortion (Spontaneous or Induced)

- Timing: The implant can be inserted within the first 7 days, including immediately after the abortion (U.S. MEC 1).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days unless the implant is placed at the time of a surgical abortion.

Switching from Another Contraceptive Method

- Timing: The implant can be inserted immediately if it is reasonably certain that the woman is not pregnant (see Box 1 above). Waiting for her next menstrual period is unnecessary.
- Need for back-up contraception: If it has been >5 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days after insertion.
- Switching from an IUD: If the woman has had sexual intercourse since the start of her current menstrual cycle and it has been >5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A healthcare provider may consider any of the following options:
    - Advise the woman to retain the IUD for at least 7 days after the implant is inserted and return for IUD removal.
    - Advise the woman to abstain from sexual intercourse or use barrier contraception for 7 days before removing the IUD and switching to the new method.
    - Advise the woman to use ECPs at the time of IUD removal.

Examinations and Tests Needed before Implant Insertion

Among healthy women, no examinations or tests are needed before initiation of an implant, although a baseline weight and BMI measurement might be useful for monitoring implant users over time (see Table 3 in the original guideline document). Women with known medical problems or other special conditions might need additional examinations or tests before being determined to be appropriate candidates for a particular method of contraception. U.S. MEC might be useful in such circumstances.

Routine Follow-Up after Implant Insertion

These recommendations address when routine follow-up is needed for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions.

- Advise a woman to return at any time to discuss side effects or other problems, if she wants to change the method being used, and when it is time to remove or replace the contraceptive method. No routine follow-up visit is required.
- At other routine visits, health-care providers seeing implant users should do the following:
    - Assess the woman's satisfaction with her contraceptive method and whether she has any concerns about method use.
    - Assess any changes in health status, including medications, that would change the appropriateness of the implant for safe and effective continued use based on U.S. MEC (e.g., category 3 and 4 conditions and characteristics).
    - Consider assessing weight changes and counseling women who are concerned about weight changes perceived to be associated with their contraceptive method.

Bleeding Irregularities (Including Amenorrhea) during Implant Use

- Before implant insertion, provide counseling about potential changes in bleeding patterns during implant use. Unscheduled spotting or light bleeding is common with implant use, and some women experience amenorrhea. These bleeding changes are generally not harmful and might or might not decrease with continued implant use. Heavy or prolonged bleeding, unscheduled or menstrual, is uncommon during implant use.

Irregular Bleeding (Spotting, Light Bleeding, or Heavy or Prolonged Bleeding)

- If clinically indicated, consider an underlying gynecological problem, such as interactions with other medications, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids). If an underlying gynecological problem is found, treat the condition or refer for care.
- If an underlying gynecologic problem is not found and the woman wants treatment, the following treatment options during days of bleeding can be considered:
    - NSAIDs for short-term treatment (5–7 days)
    - Hormonal treatment (if medically eligible) with low dose combined oral contraceptives (COC) or estrogen for short term treatment (10–20 days)
- If irregular bleeding persists and the woman finds it unacceptable, counsel her on alternative methods, and offer another method if it is desired.

Amenorrhea

- Amenorrhea does not require any medical treatment. Provide reassurance.
  - If a woman's regular bleeding pattern changes abruptly to amenorrhea, consider ruling out pregnancy if clinically indicated.
- If amenorrhea persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Injectables

Progestin-only injectable contraceptives (DMPA, 150 mg intramuscularly or 104 mg subcutaneously) are available in the United States; the only difference between these two formulations is the route of administration. Approximately 6 out of 100 women will become pregnant in the first year of use of DMPA with typical use. DMPA is reversible and can be used by women of all ages, including adolescents. DMPA does not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, including HIV.

Initiation of Injectables

Timing

- The first DMPA injection can be given at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).

Need for Back-Up Contraception

- If DMPA is started within the first 7 days since menstrual bleeding started, no additional contraceptive protection is needed.
- If DMPA is started >7 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Special Considerations

Amenorrhea (Not Postpartum)

- Timing: The first DMPA injection can be given at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (Breastfeeding)

- Timing: The first DMPA injection can be given at any time, including immediately postpartum (U.S. MEC 2 if <1 month postpartum and U.S. MEC 1 if ≥1 month postpartum) if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: If the woman is <6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), no additional contraceptive protection is needed. Otherwise, a woman who is ≥21 days postpartum and has not experienced return of her menstrual cycle needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. If her menstrual cycles have returned and it has been >7 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (Not Breastfeeding)

- Timing: The first DMPA injection can be given at any time, including immediately postpartum (U.S. MEC 1) if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: A woman who is ≥21 days postpartum and has not experienced return of her menstrual cycle needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. If her menstrual cycles have returned and it has been >7 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postabortion (Spontaneous or Induced)

- Timing: The first DMPA injection can be given within the first 7 days, including immediately postabortion (U.S. MEC 1).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days unless the injection is given at the time of a surgical abortion.

Switching from Another Contraceptive Method

- Timing: The first DMPA injection can be given immediately if it is reasonably certain that the woman is not pregnant (see Box 1 above). Waiting for her next menstrual period is unnecessary.
- Need for back-up contraception: If it has been >7 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
- Switching from an IUD: If the woman has had sexual intercourse since the start of her current menstrual cycle and it has been >5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A healthcare provider may consider any of the following options:
    - Advise the women to retain the IUD for at least 7 days after the injection and return for IUD removal.
    - Advise the woman to abstain from sexual intercourse or use barrier contraception for 7 days before removing the IUD and switching to the new method.
    - Advise the woman to use ECPs at the time of IUD removal.

Examinations and Tests Needed before Initiation of an Injectable

Among healthy women, no examinations or tests are needed before initiation of DMPA, although a baseline weight and BMI measurement might be useful for monitoring DMPA users over time (see Table 4 in the original guideline document). Women with known medical problems or other special conditions might need additional examinations or tests before being determined to be appropriate candidates for a particular method of contraception. U.S. MEC might be useful in such circumstances.

Routine Follow-Up after Injectable Initiation

These recommendations address when routine follow-up is recommended for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions.

- Advise a woman to return at any time to discuss side effects or other problems, if she wants to change the method being used, and when it is time for reinjection. No routine follow-up visit is required.
- At other routine visits, health-care providers seeing injectable users should do the following:
    - Assess the woman's satisfaction with her contraceptive method and whether she has any concerns about method use.
    - Assess any changes in health status, including medications, that would change the appropriateness of the injectable for safe and effective continued use based on U.S. MEC (e.g., category 3 and 4 conditions and characteristics).
    - Consider assessing weight changes and counseling women who are concerned about weight changes perceived to be associated with their contraceptive method.

Timing of Repeat Injections

Reinjection Interval

- Provide repeat DMPA injections every 3 months (13 weeks).

Special Considerations

Early Injection

- The repeat DMPA injection can be given early when necessary.

Late Injection

- The repeat DMPA injection can be given up to 2 weeks late (15 weeks from the last injection) without requiring additional contraceptive protection.
- If the woman is >2 weeks late (>15 weeks from the last injection) for a repeat DMPA injection, she can have the injection if it is reasonably certain that she is not pregnant (see Box 1 above). She needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. She might consider the use of emergency contraception if appropriate.

Bleeding Irregularities (Including Amenorrhea) during Injectable Use

Before DMPA initiation, provide counseling about potential changes in bleeding patterns during DMPA use. Amenorrhea and unscheduled spotting or light bleeding is common with DMPA use, and heavy or prolonged bleeding can occur with DMPA use. These bleeding irregularities are

generally not harmful and might decrease with continued DMPA use.

Unscheduled Spotting or Light Bleeding

- If clinically indicated, consider an underlying gynecological problem, such as interactions with other medications, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids). If an underlying gynecological problem is found, treat the condition or refer for care.
- If an underlying gynecologic problem is not found and the woman wants treatment, the following treatment option during days of bleeding can be considered:
  - NSAIDs for short-term treatment (5–7 days)
- If unscheduled spotting or light bleeding persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Heavy or Prolonged Bleeding

- If clinically indicated, consider an underlying gynecological problem, such as interactions with other medications, an STD, pregnancy, or new pathologic uterine conditions (such as fibroids or polyps). If an underlying gynecologic problem is identified, treat the condition or refer for care.
- If an underlying gynecologic problem is not found and the woman wants treatment, the following treatment options during days of bleeding can be considered:
  - NSAIDs for short-term treatment (5–7 days)
  - Hormonal treatment (if medically eligible) with low-dose combined oral contraceptives (COCs) or estrogen for short-term treatment (10–20 days)
- If heavy or prolonged bleeding persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Amenorrhea

- Amenorrhea does not require any medical treatment. Provide reassurance.
  - If a woman's regular bleeding pattern changes abruptly to amenorrhea, consider ruling out pregnancy if clinically indicated.
- If amenorrhea persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Combined Hormonal Contraceptives

Combined hormonal contraceptives contain both estrogen and a progestin and include 1) COCs (various formulations), 2) a transdermal contraceptive patch (which releases 150 µg of norelgestromin and 20 µg ethinyl estradiol daily), and 3) a vaginal contraceptive ring (which releases 120 µg etonogestrel and 15 µg ethinyl estradiol daily). Approximately 9 out of 100 women become pregnant in the first year of use with combined hormonal contraceptives with typical use. These methods are reversible and can be used by women of all ages. Combined hormonal contraceptives are generally used for 21 to 24 consecutive days, followed by 4 to 7 hormone-free days (either no use or placebo pills). These methods are sometimes used for an extended period with infrequent or no hormone free days. Combined hormonal contraceptives do not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, including HIV.

Initiation of Combined Hormonal Contraceptives

Timing

- Combined hormonal contraceptives can be initiated at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).

Need for Back-Up Contraception

- If combined hormonal contraceptives are started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
- If combined hormonal contraceptives are started >5 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Special Considerations

Amenorrhea (Not Postpartum)

- Timing: Combined hormonal contraceptives can be started at any time if it is reasonably certain that the woman is not pregnant (see Box 1

above).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (Breastfeeding)

- Timing: Combined hormonal contraceptives can be started when the woman is medically eligible to use the method and if it is reasonably certain that she is not pregnant (see Box 1 above).
    - Postpartum women who are breastfeeding should not use combined hormonal contraceptives during the first 3 weeks after delivery (U.S. MEC 4) because of concerns about increased risk for venous thromboembolism and generally should not use combined hormonal contraceptives during the fourth week postpartum (U.S. MEC 3) because of concerns about potential effects on breastfeeding performance. Postpartum, breastfeeding women with other risk factors for venous thromboembolism generally should not use combined hormonal contraceptives 4 to 6 weeks after delivery (U.S. MEC 3).
- Need for back-up contraception: If the woman is <6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), no additional contraceptive protection is needed. Otherwise, a woman who is ≥21 days postpartum and has not experienced return of her menstrual cycle needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. If her menstrual cycles have returned and it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (Not Breastfeeding)

- Timing: Combined hormonal contraceptives can be started when the woman is medically eligible and if it is reasonably certain that she is not pregnant (see Box 1 above).
    - Postpartum women should not use combined hormonal contraceptives during the first 3 weeks after delivery (U.S. MEC 4) because of concerns about increased risk for venous thromboembolism. Postpartum women with other risk factors for venous thromboembolism generally should not use combined hormonal contraceptives 3 to 6 weeks after delivery (U.S. MEC 3).
- Need for back-up contraception: A woman who is ≥21 days postpartum and whose menstrual cycles have not returned needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. If her menstrual cycles have returned and it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postabortion (Spontaneous or Induced)

- Timing: Combined hormonal contraceptives can be started within the first 7 days after first or second trimester abortion, including immediately postabortion (U.S. MEC 1).
- Need for back-up contraception: She needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days unless combined hormonal contraceptives are started at the time of a surgical abortion.

Switching from Another Contraceptive Method

- Timing: Combined hormonal contraceptives can be started immediately if it is reasonably certain that the woman is not pregnant (see Box 1 above). Waiting for her next menstrual period is unnecessary.
- Need for back-up contraception: If it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
- Switching from an IUD: If the woman has had sexual intercourse since the start of her current menstrual cycle and it has been >5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A healthcare provider may consider any of the following options:
    - Advise the women to retain the IUD for at least 7 days after combined hormonal contraceptives are initiated and return for IUD removal.
    - Advise the woman to abstain from sexual intercourse or use barrier contraception for 7 days before removing the IUD and switching to the new method.
    - Advise the woman to use ECPs at the time of IUD removal.

Examinations and Tests Needed before Initiation of Combined Hormonal Contraceptives

Among healthy women, few examinations or tests are needed before initiation of combined hormonal contraceptives (see Table 5 in the original guideline document). Blood pressure should be measured before initiation of combined hormonal contraceptives. Baseline weight and BMI measurements might be useful for monitoring combined hormonal contraceptive users over time. Women with known medical problems or other

special conditions might need additional examinations or tests before being determined to be appropriate candidates for a particular method of contraception. U.S. MEC might be useful in such circumstances.

Number of Pill Packs That Should Be Provided at Initial and Return Visits

- At the initial and return visits, provide or prescribe up to a 1-year supply of COCs (e.g., 13 28-day pill packs), depending on the woman's preferences and anticipated use.
- A woman should be able to obtain COCs easily in the amount and at the time she needs them.

Routine Follow-Up after Combined Hormonal Contraceptive Initiation

These recommendations address when routine follow-up is recommended for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions.

- Advise a woman to return at any time to discuss side effects or other problems or if she wants to change the method being used. No routine follow-up visit is required.
- At other routine visits, health-care providers seeing combined hormonal contraceptive users should do the following:
    - Assess the woman's satisfaction with her contraceptive method and whether she has any concerns about method use.
    - Assess any changes in health status, including medications, that would change the appropriateness of combined hormonal contraceptives for safe and effective continued use based on U.S. MEC (e.g., category 3 and 4 conditions and characteristics).
    - Assess blood pressure.
    - Consider assessing weight changes and counseling women who are concerned about weight changes perceived to be associated with their contraceptive method.

Late or Missed Doses and Side Effects from Combined Hormonal Contraceptive Use

For the following recommendations, a dose is considered late when <24 hours have elapsed since the dose should have been taken. A dose is considered missed if ≥24 hours have elapsed since the dose should have been taken. For example, if a COC pill was supposed to have been taken on Monday at 9:00 a.m. and is taken at 11:00 a.m., the pill is late; however, by Tuesday morning at 11:00 a.m., Monday's 9:00 a.m. pill has been missed and Tuesday's 9:00 a.m. pill is late. For COCs, the recommendations only apply to late or missed hormonally active pills and not to placebo pills. Recommendations are provided for late or missed pills (see Figure 2 in the original guideline document), the patch (see Figure 3 in the original guideline document), and the ring (see Figure 4 in the original guideline document).

Vomiting or Severe Diarrhea While Using COCs

Certain steps should be taken by women who experience vomiting or severe diarrhea while using COCs (see Figure 5 in the original guideline document).

Unscheduled Bleeding with Extended or Continuous Use of Combined Hormonal Contraceptives

- Before initiation of combined hormonal contraceptives, provide counseling about potential changes in bleeding patterns during extended or continuous combined hormonal contraceptive use. (Extended contraceptive use is defined as a planned hormone-free interval after at least two contiguous cycles. Continuous contraceptive use is defined as uninterrupted use of hormonal contraception without a hormone-free interval.)
- Unscheduled spotting or bleeding is common during the first 3 to 6 months of extended or continuous combined hormonal contraceptive use. It is generally not harmful and decreases with continued combined hormonal contraceptive use.
- If clinically indicated, consider an underlying gynecological problem, such as inconsistent use, interactions with other medications, cigarette smoking, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids). If an underlying gynecological problem is found, treat the condition or refer for care.
- If an underlying gynecological problem is not found and the woman wants treatment, the following treatment option can be considered:
    - Advise the woman to discontinue combined hormonal contraceptive use (i.e., a hormone-free interval) for 3 to 4 consecutive days; a hormone-free interval is not recommended during the first 21 days of using the continuous or extended combined hormonal contraceptive method. A hormone-free interval also is not recommended more than once per month because contraceptive effectiveness might be reduced.
- If unscheduled spotting or bleeding persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Progestin-Only Pills (POP)

POPs contain only a progestin and no estrogen and are available in the United States. Approximately 9 out of 100 women become pregnant in the first year of use with POPs with typical use. POPs are reversible and can be used by women of all ages. POPs do not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, including HIV.

Initiation of POPs

Timing

- POPs can be started at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).

Need for Back-Up Contraception

- If POPs are started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
- If POPs are started >5 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.

Special Considerations

Amenorrhea (Not Postpartum)

- Timing: POPs can be started at any time if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.

Postpartum (Breastfeeding)

- Timing: POPs can be started at any time, including immediately postpartum (U.S. MEC 2 if <1 month postpartum and U.S. MEC 1 if ≥1 month postpartum) if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: If the woman is <6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), no additional contraceptive protection is needed. Otherwise, a woman who is ≥21 days postpartum and has not experienced return of her menstrual cycles needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days. If her menstrual cycles have returned and it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.

Postpartum (Not Breastfeeding)

- Timing: POPs can be started at any time, including immediately postpartum (U.S. MEC 1), if it is reasonably certain that the woman is not pregnant (see Box 1 above).
- Need for back-up contraception: Women who are ≥21 days postpartum and whose menstrual cycles have not returned need to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days. If her menstrual cycles have returned and it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.

Postabortion (Spontaneous or Induced)

- Timing: POPs can be started within the first 7 days, including immediately postabortion (U.S. MEC 1).
- Need for back-up contraception: The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days unless POPs are started at the time of a surgical abortion.

Switching from Another Contraceptive Method

- Timing: POPs can be started immediately if it is reasonably certain that the woman is not pregnant (see Box 1 above). Waiting for her next menstrual period is unnecessary.
- Need for back-up contraception: If it has been >5 days since menstrual bleeding started, she needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.
- Switching from an IUD: If the woman has had sexual intercourse since the start of her current menstrual cycle and it has been >5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A healthcare provider may consider any of the following options:

- Advise the women to retain the IUD for at least 2 days after POPs are initiated and return for IUD removal.
- Advise the woman to abstain from sexual intercourse or use barrier contraception for 2 days before removing the IUD and switching to the new method.
- Advise the woman to use ECPs at the time of IUD removal.

Examinations and Tests Needed before Initiation of POPs

Among healthy women, no examinations or tests are needed before initiation of POPs, although a baseline weight and BMI measurement might be useful for monitoring POP users over time (see Table 6 in the original guideline document). Women with known medical problems or other special conditions might need additional examinations or tests before being determined to be appropriate candidates for a particular method of contraception. U.S. MEC might be useful in such circumstances.

Number of Pill Packs That Should Be Provided at Initial and Return Visits

- At the initial and return visits, provide or prescribe up to a 1-year supply of POPs (e.g., 13 28-day pill packs), depending on the woman's preferences and anticipated use.
- A woman should be able to obtain POPs easily in the amount and at the time she needs them.

Routine Follow-Up after POP Initiation

These recommendations address when routine follow-up is recommended for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions.

- Advise a woman to return at any time to discuss side effects or other problems or if she wants to change the method being used. No routine follow-up visit is required.
- At other routine visits, health-care providers seeing POP users should do the following:
  - Assess the woman's satisfaction with her contraceptive method and whether she has any concerns about method use.
  - Assess any changes in health status, including medications, that would change the appropriateness of POPs for safe and effective continued use based on U.S. MEC (e.g., category 3 and 4 conditions and characteristics).
  - Consider assessing weight changes and counseling women who are concerned about weight changes perceived to be associated with their contraceptive method.

Missed POPs

For the following recommendations, a dose is considered missed if it has been >3 hours since it should have been taken.

- Take one pill as soon as possible.
- Continue taking pills daily, one each day, at the same time each day, even if it means taking two pills on the same day.
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until pills have been taken correctly, on time, for 2 consecutive days.
- Emergency contraception should be considered if the woman has had unprotected sexual intercourse.

Vomiting or Severe Diarrhea (for Any Reason or Duration) That Occurs within 3 Hours after Taking a Pill

- Take another pill as soon as possible (if possible, despite discomfort).
- Continue taking pills daily, one each day, at the same time each day.
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until 2 days after vomiting or diarrhea has resolved.
- Emergency contraception should be considered if the woman has had unprotected sexual intercourse.

Standard Days Method (SDM)

SDM is a method based on fertility awareness; users must avoid unprotected sexual intercourse on days 8 to 19 of the menstrual cycle. Approximately 5 out of 100 women become pregnant in the first year of use with perfect (i.e., correct and consistent) use of SDM; effectiveness based on typical use is not available for this method but is expected to be lower than that for perfect use. SDM is reversible and can be used by women of all ages. SDM does not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, including HIV.

Use of SDM among Women with Various Menstrual Cycle Durations

Menstrual Cycles of 26 to 32 Days

- These women may use the method.
- Provide a barrier method of contraception for protection on days 8 to 19 if she wants one.
- If she has unprotected sexual intercourse during days 8 to 19, consider the use of emergency contraception if appropriate.

Two or More Menstrual Cycles of <26 or >32 Days within Any 1 Year of SDM Use

- Advise the woman that the method might not be appropriate for her because of a higher risk for pregnancy. Help her consider another method.

Emergency Contraception

Emergency contraception consists of methods that can be used by women after sexual intercourse to prevent pregnancy. Emergency contraception methods have varying ranges of effectiveness depending on the method and timing of administration. Four options are available in the United States: the Cu-IUD and three types of ECPs.

Types of Emergency Contraception

Intrauterine Device

- Cu-IUD

ECPs

- Ulipristal acetate (UPA) in a single dose (30 mg)
- Levonorgestrel in a single dose (1.5 mg) or as a split dose (1 dose of 0.75 mg of levonorgestrel followed by a second dose of 0.75 mg of levonorgestrel 12 hours later)
- Combined estrogen and progestin in 2 doses (Yuzpe regimen: 1 dose of 100 µg of ethinyl estradiol plus 0.50 mg of levonorgestrel followed by a second dose of 100 µg of ethinyl estradiol plus 0.50 mg of levonorgestrel 12 hours later)

Initiation of Emergency Contraception

Timing

Cu-IUD

- The Cu-IUD can be inserted within 5 days of the first act of unprotected sexual intercourse as an emergency contraceptive.
- In addition, when the day of ovulation can be estimated, the Cu-IUD can be inserted beyond 5 days after sexual intercourse, as long as insertion does not occur >5 days after ovulation.

ECPs

- ECPs should be taken as soon as possible within 5 days of unprotected sexual intercourse.

Advance Provision of ECPs

- An advance supply of ECPs may be provided so that ECPs will be available when needed and can be taken as soon as possible after unprotected sexual intercourse.

Initiation of Regular Contraception after ECPs

UPA

- Any regular contraceptive method can be started immediately after the use of UPA.
- The woman needs to abstain from sexual intercourse or use barrier contraception for 14 days or until her next menses, whichever comes first.
- Advise the woman to have a pregnancy test if she does not have a withdrawal bleed within 3 weeks.

Levonorgestrel and Combined Estrogen and Progestin ECPs

- Any regular contraceptive method can be started immediately after the use of levonorgestrel or combined estrogen and progestin ECPs.
- The woman needs to abstain from sexual intercourse or use barrier contraception for 7 days.
- Advise the woman to have a pregnancy test if she does not have a withdrawal bleed within 3 weeks.

Prevention and Management of Nausea and Vomiting with ECP Use

Nausea and Vomiting

- Levonorgestrel and UPA ECPs cause less nausea and vomiting than combined estrogen and progestin ECPs.
- Routine use of antiemetics before taking ECPs is not recommended. Pretreatment with antiemetics may be considered depending on availability and clinical judgment.

Vomiting within 3 Hours of Taking ECPs

- Another dose of ECP should be taken as soon as possible. Use of an antiemetic should be considered.

Female Sterilization

Laparoscopic, abdominal, and hysteroscopic methods of female sterilization are available in the United States, and some of these procedures can be performed in an outpatient procedure or office setting. Fewer than 1 out of 100 women become pregnant in the first year after female sterilization. Because these methods are intended to be irreversible, all women should be appropriately counseled about the permanency of sterilization and the availability of highly effective, long-acting, reversible methods of contraception. Female sterilization does not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, including HIV.

When Hysteroscopic Sterilization Is Reliable for Contraception

- Before a woman can rely on hysteroscopic sterilization for contraception, a hysterosalpingogram (HSG) must be performed 3 months after the sterilization procedure to confirm bilateral tubal occlusion.
- The woman should be advised that she needs to abstain from sexual intercourse or use additional contraceptive protection until she has confirmed bilateral tubal occlusion.

When Laparoscopic and Abdominal Approaches Are Reliable for Contraception

- A woman can rely on sterilization for contraception immediately after laparoscopic and abdominal approaches. No additional contraceptive protection is needed.

Male Sterilization

Male sterilization, or vasectomy, is one of the few contraceptive methods available to men and can be performed in an outpatient procedure or office setting. Fewer than 1 woman out of 100 becomes pregnant in the first year after her male partner undergoes sterilization. Because male sterilization is intended to be irreversible, all men should be appropriately counseled about the permanency of sterilization and the availability of highly effective, long-acting, reversible methods of contraception for women. Male sterilization does not protect against STDs; consistent and correct use of male latex condoms reduces the risk for STDs, including HIV.

When Vasectomy Is Reliable for Contraception

- A semen analysis should be performed 8 to 16 weeks after a vasectomy to ensure the procedure was successful.
- The man should be advised that he should use additional contraceptive protection or abstain from sexual intercourse until he has confirmation of vasectomy success by postvasectomy semen analysis.

Other Postprocedure Recommendations

- The man should refrain from ejaculation for approximately 1 week after the vasectomy to allow for healing of surgical sites and, after certain methods of vasectomy, occlusion of the vas.

When Women Can Stop Using Contraceptives

- Contraceptive protection is still needed for women aged >44 years if the woman wants to avoid pregnancy.

Clinical Algorithm(s)

The following clinical algorithms are provided in the original guideline document:

- Management of Women with Bleeding Irregularities While Using Contraception (Appendix E)
- Management of the IUD When a Cu-IUD or an LNG-IUD User Is Found To Have Pelvic Inflammatory Disease (Appendix F)

Scope

Disease/Condition(s)

Unintended pregnancy

Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Infectious Diseases

Internal Medicine

Obstetrics and Gynecology

Pediatrics

Pharmacology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Pharmacists

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

To help health-care providers address issues related to use of contraceptives, such as:

- How to help a woman initiate use of a contraceptive method
- Which examinations and tests are needed before initiating use of a contraceptive method
- What regular follow-up is needed
- How to address problems that often arise during use, including missed pills and side effects such as unscheduled bleeding

Target Population

All women of reproductive age (including adolescents) and their male partners residing in the United States

Interventions and Practices Considered

Contraception Methods

1. Intrauterine contraception, including copper-containing intrauterine device (Cu-IUD) and levonorgestrel-releasing IUD (LNG-IUD)
2. Etonogestrel implant
3. Depot medroxyprogesterone acetate (DMPA) injectable contraceptive
4. Combined hormonal contraceptives containing both estrogen and a progestin including:
    - Combined oral contraceptives (COCs) (various formulations)
    - Transdermal contraceptive patch
    - Vaginal contraceptive ring
5. Progestin-only pills (POPs)
6. Standard days method (based on fertility awareness)
7. Emergency contraception including:
    - Cu-IUD
    - Ulipristal acetate (UPA) in a single dose
    - Levonorgestrel in a single dose or as a split dose
    - Combined estrogen and progestin in 2 doses (Yuzpe regimen)
8. Female sterilization (laparoscopic, abdominal, and hysteroscopic methods)
9. Male sterilization (vasectomy)

Initiation of Contraception

1. Ascertaining that woman is not pregnant
2. Timing of IUD or implant insertion or initiation of other hormonal contraceptive methods
3. Clinical examinations and laboratory tests needed before initiation of contraceptive methods (e.g., cervical examination and screening tests for sexually transmitted diseases [STDs])
4. Provision of prophylactic antibiotics at the time of IUD insertion (not generally recommended)
5. Advice on need for back-up contraception
6. Special considerations for amenorrhea (not postpartum), postpartum (including after cesarean section), postpartum (breastfeeding and not breastfeeding), postabortion, switching from anther contraceptive method
7. Counseling on potential changes in bleeding patterns and amenorrhea that occur with various contraceptive methods

Management of Contraception and Follow-up

1. Management of bleeding irregularities
2. Management of the IUD when a Cu-IUD or an LNG-IUD user is found to have pelvic inflammatory disease (PID) or when the user is found to be pregnant
3. Routine follow-up after IUD or implant insertion or after initiation of hormonal methods of contraception
4. Number of contraceptive pills to be provided at initial and return visits
5. Considerations for missed pills and vomiting or diarrhea while taking pills
6. Prevention and management of nausea and vomiting with emergency contraceptive pill use

7. Starting regular contraception after use of emergency contraception
8. Stopping contraceptive protection (age for discontinuation)

Major Outcomes Considered

- Effectiveness of contraceptive methods
- Safety of contraceptive methods
- Satisfaction/side effects regarding contraceptive methods
- Unintended pregnancy rates

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Representatives from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) conducted systematic reviews of the scientific evidence for each of the WHO recommendations being considered for adaptation and for each new topic being considered for addition to the guidance. The purpose of these systematic reviews was to identify evidence related to the common clinical challenges associated with the recommendations. When no direct evidence was available, indirect evidence and theoretical issues were considered.

Some of the examinations or tests that are not deemed necessary for safe and effective contraceptive use might be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions. Systematic reviews were conducted for several different types of examinations and tests to assess whether a screening test was associated with safe use of contraceptive methods. Because no single convention exists for screening panels for certain diseases, including diabetes, lipid disorders, and liver diseases, the search strategies included broad terms for the tests and diseases of interest.

For more information on the literature search strategies, see the "Materials" and "Methods" sections of the individual systematic reviews listed in the "Availability of Companion Documents" field.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Not Given)

Rating Scheme for the Strength of the Evidence

Strength and quality of the evidence were graded using the system of the U.S. Preventive Services Task Force (2001).

For more information, see the "Materials" and "Methods" sections of the individual systematic reviews listed in the "Availability of Companion Documents" field.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Description of the Methods Used to Analyze the Evidence

Representatives from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) conducted systematic reviews of the scientific evidence for each of the WHO recommendations being considered for adaptation and for each new topic being considered for addition to the guidance. The purpose of these systematic reviews was to identify evidence related to the common clinical challenges associated with the recommendations. When no direct evidence was available, indirect evidence and theoretical issues were considered. Standard guidelines were followed for reporting systematic reviews, and strength and quality of the evidence were graded using the system of the U.S. Preventive Services Task Force.

For more information, see the "Materials" and "Methods" sections of the individual systematic reviews listed in the "Availability of Companion Documents" field.

Methods Used to Formulate the Recommendations

Expert Consensus

Expert Consensus (Consensus Development Conference)

Description of Methods Used to Formulate the Recommendations

The Centers for Disease Control and Prevention (CDC) initiated a process to adapt the *World Health Organization Selected Practice Recommendations for Contraceptive Use* (WHO SPR) for the United States. This adaptation process included four steps: 1) determining the scope of and process for the adaptation, including an October 2010 meeting in which individual feedback was solicited from a small group of partners and experts; 2) preparing the systematic reviews of the evidence during October 2010 to September 2011 to be used for the adaptation, including peer review; 3) convening a larger meeting of experts in October 2011 to examine the evidence and receive input on the recommendations; and 4) finalizing recommendations by CDC.

During October 21–22, 2010, CDC convened a meeting of 10 partners and U.S. family planning experts in Atlanta, Georgia, to discuss the scope of and process for a U.S. adaptation of WHO SPR. A list of participants is provided at the end of the guideline document. CDC identified the specific WHO recommendations that might benefit from modification for the United States. Criteria used to modify the WHO recommendations included the availability of new scientific evidence or the context in which family planning services are provided in the United States. CDC also identified several WHO recommendations that needed additional specificity to be useful for U.S. health-care providers, as well as the need for additional recommendations not currently included in WHO SPR. In addition, the meeting members discussed removing recommendations that provide information about contraceptive methods that are not available in the United States.

Representatives from CDC and WHO conducted systematic reviews of the scientific evidence for each of the WHO recommendations being considered for adaptation and for each new topic being considered for addition to the guidance. The purpose of these systematic reviews was to identify evidence related to the common clinical challenges associated with the recommendations. When no direct evidence was available, indirect evidence and theoretical issues were considered. Standard guidelines were followed for reporting systematic reviews, and strength and quality of the evidence were graded using the system of the U.S. Preventive Services Task Force.

Each complete systematic review was peer reviewed by two or three experts before its use in the adaptation process. Peer reviewers, who were identified from the list of persons scheduled to participate in the October 2011 meeting, were asked to comment on the search strategy, list of articles included in the reviews, and the summary of findings. The systematic reviews were finalized and provided to participants before the October 2011 meeting and were published in May 2013.

During October 4–7, 2011, CDC convened a meeting in Atlanta, Georgia, of 36 experts who were invited to assist in guideline development and provide their perspective on the scientific evidence presented and the discussions on potential recommendations that followed. The group included obstetrician/gynecologists, pediatricians, family physicians, nurse-midwives, nurse practitioners, epidemiologists, and others with research and clinical practice expertise in contraceptive safety, effectiveness, and management. All participants received all of the systematic reviews before the meeting. During the meeting, the evidence from the systematic review for each topic was presented, and participants discussed the evidence and the translation of the scientific evidence into recommendations that would meet the needs of U.S. healthcare providers. In particular, participants discussed whether and how the U.S. context might be different from the global context and whether these differences suggested any need for

modifications to the global guidance. CDC gathered the input from the experts during the meeting and finalized the recommendations.

Rating Scheme for the Strength of the Recommendations

The following classification system was developed by the World Health Organization (WHO) and adopted by the Centers for Disease Control and Prevention (CDC) to categorize the applicability of the various examinations or tests before initiation of contraceptive methods:

Class A: These tests and examinations are essential and mandatory in all circumstances for safe and effective use of the contraceptive method.

Class B: These tests and examinations contribute substantially to safe and effective use, although implementation can be considered within the public health context, service context, or both. The risk for not performing an examination or test should be balanced against the benefits of making the contraceptive method available.

Class C: These tests and examinations do not contribute substantially to safe and effective use of the contraceptive method.

Cost Analysis

Published cost analyses were reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

During October 4–7, 2011, CDC convened a meeting in Atlanta, Georgia, of 36 experts who were invited to assist in guideline development and provide their perspective on the scientific evidence presented and the discussions on potential recommendations that followed. The finalized guideline document was peer reviewed by meeting participants, who were asked to comment on specific issues that were raised during the meeting. Feedback also was received from an external review panel, composed of health-care providers who had not participated in the adaptation meetings. These providers were asked to provide comments on the accuracy, feasibility, and clarity of the recommendations, as well as to provide other comments.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The recommendations are based on the World Health Organization selected practice recommendations for contraceptive use, 2nd Edition, and the results from various systematic reviews (see the "Availability of Companion Documents" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Medically appropriate contraception assessment, counseling, and approach for individual circumstances
- Prevention of unintended pregnancy

Potential Harms

- Unscheduled spotting or light bleeding or heavy or prolonged menstrual bleeding, especially during the first 3 to 6 months of use, are common with intrauterine devices (IUDs). Bleeding irregularities, including amenorrhea, commonly occur with implants, injectables, and other hormonal contraceptive methods.
- Risks for spontaneous abortion, preterm delivery, and infection are substantial if the IUD is left in place during pregnancy. Theoretically, the fetus might be affected by hormonal exposure from a levonorgestrel-releasing IUD (LNG-IUD); however, whether this exposure increases the risk for fetal abnormalities is unknown. A systematic review identified nine studies suggesting that women who did not remove their IUDs during pregnancy were at greater risk for adverse pregnancy outcomes (including spontaneous abortion, septic abortion, preterm delivery, and chorioamnionitis) compared with women who had their IUDs removed or who did not have an IUD. Copper-containing IUD (Cu-IUD) removal decreased risks but not to the baseline risk for pregnancies without an IUD. One case series examined LNG-IUDs. When they were not removed, eight in 10 pregnancies ended in spontaneous abortions.
- Theoretically, IUD insertion could induce bacterial spread and lead to complications such as pelvic inflammatory disease (PID) or infective endocarditis. A meta-analysis was conducted of randomized controlled trials examining antibiotic prophylaxis versus placebo or no treatment for IUD insertion. Use of prophylaxis reduced the frequency of unscheduled return visits but did not significantly reduce the incidence of PID or premature IUD discontinuation. Although the risk for PID was higher within the first 20 days after insertion, the incidence of PID was low among all women who had IUDs inserted. Studies have not demonstrated a conclusive link between genitourinary procedures and infective endocarditis or a preventive benefit of prophylactic antibiotics during such procedures.
- In choosing a method of contraception, the risk for human immunodeficiency virus (HIV) infection and other sexually transmitted diseases (STDs) also should be considered. Although hormonal contraceptives and IUDs are highly effective at preventing pregnancy, they do not protect against STDs and HIV.
- Although hormonal contraceptives can have some adverse effects on glucose metabolism in healthy and diabetic women, the overall clinical effect is minimal.
- Women taking combined estrogen and progestin emergency contraception pills (ECPs) are more likely to experience nausea and vomiting than those who take levonorgestrel or ulipristal acetate ECPs.
- Health-care providers should consider the risks for becoming pregnant in a woman of advanced reproductive age, as well as any risks of continuing contraception until menopause. Pregnancies among women of advanced reproductive age are at higher risk for maternal complications, such as hemorrhage, venous thromboembolism, and death, and fetal complications, such as spontaneous abortion, stillbirth, and congenital anomalies. Risks associated with continuing contraception, in particular risks for acute cardiovascular events (venous thromboembolism, myocardial infarction, or stroke) or breast cancer, also are important to consider.
- Table 1 in the original guideline document shows failure rates for individual contraceptive methods.
- The U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 (U.S. MEC), focuses on who can safely use specific methods of contraception and provides recommendations for the safety of contraceptive methods for women with various medical conditions (e.g., hypertension and diabetes) and characteristics (e.g., age, parity, and smoking status). See Appendix A in the original guideline document for a summary chart of the U.S. MEC.

Contraindications

Contraindications

Combined Hormonal Contraceptives

- Postpartum women who are breastfeeding should not use combined hormonal contraceptives during the first 3 weeks after delivery (U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 [U.S. MEC 4]) because of concerns about increased risk for venous thromboembolism and generally should not use combined hormonal contraceptives during the fourth week postpartum (U.S. MEC 3) because of concerns about potential effects on breastfeeding performance. Postpartum, breastfeeding women with other risk factors for venous thromboembolism generally should not use combined hormonal contraceptives 4 to 6 weeks after delivery (U.S. MEC 3).
- Postpartum women who are not breastfeeding should not use combined hormonal contraceptives during the first 3 weeks after delivery (U.S. MEC 4) because of concerns about increased risk for venous thromboembolism. Postpartum women with other risk factors for venous thromboembolism generally should not use combined hormonal contraceptives 3 to 6 weeks after delivery (U.S. MEC 3).
- Women who have more severe hypertension (systolic pressure of ≥160 mm Hg or diastolic pressure of ≥100 mm Hg) or vascular disease should not use combined hormonal contraceptives (U.S. MEC 4), and women who have less severe hypertension (systolic pressure of 140–159 mm Hg or diastolic pressure of 90–99 mm Hg) or adequately controlled hypertension generally should not use combined hormonal contraceptives (U.S. MEC 3).
- Women with certain conditions such as current breast cancer, severe hypertension or vascular disease, heart disease, migraine headaches

with aura, and certain liver diseases, as well as women aged ≥35 years who smoke ≥15 cigarettes per day, should not use (U.S. MEC 4) or generally should not use (U.S. MEC 3) combined hormonal contraceptives.
- Women with complicated diabetes should not use (U.S. MEC 4) or generally should not use (U.S. MEC 3) combined hormonal contraceptives, depending on the severity of the condition.

Progestin-Only Pills (POPs)

Women with current breast cancer should not use POPs (U.S. MEC 4), and women with certain liver diseases generally should not use POPs (U.S. MEC 3).

Intrauterine Devices (IUDs)

- The copper-containing intrauterine device (Cu-IUD) and levonorgestrel-releasing IUD (LNG-IUD) should not be inserted in a woman with puerperal sepsis (U.S. MEC 4) and should not be inserted immediately after septic abortion (U.S. MEC 4).
- Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (U.S. MEC 4) and women who have a very high individual likelihood of sexually transmitted disease (STD) exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion (U.S. MEC 3).
- Women with certain liver diseases generally should not use the LNG-IUD (U.S. MEC 3).
- Women with current breast cancer should not use the LNG-IUD (U.S. MEC 4).
- Women with cervical cancer should not undergo IUD insertion (U.S. MEC 4).

Implants

Women with current breast cancer should not use implants (U.S. MEC 4); women with certain liver diseases generally should not use implants (U.S. MEC 3).

Depot Medroxyprogesterone Acetate (DMPA)

- Women with current breast cancer should not use DMPA (U.S. MEC 4), and women with severe hypertension, heart disease, vascular disease, migraine headaches with aura, or certain liver diseases generally should not use DMPA (U.S. MEC 3).
- Women with complicated diabetes generally should not use DMPA (U.S. MEC 3).

See also Appendix A in the original guideline document for the Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use, 2010.

Qualifying Statements

Qualifying Statements

- These recommendations are meant to serve as a source of clinical guidance for health-care providers; health-care providers should always consider the individual clinical circumstances of each person seeking family planning services. This report is not intended to be a substitute for professional medical advice for individual patients; persons should seek advice from their health-care providers when considering family planning options.
- Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.
- References to non-Centers for Disease Control and Prevention (CDC) sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in the *MMWR* were current as of the date of publication.
- This document will not include any discussion of the unlabeled use of a product or a product under investigational use, with the exception that some of the recommendations in this document might be inconsistent with package labeling.

Implementation of the Guideline

Description of Implementation Strategy

The Centers for Disease Control and Prevention (CDC) is committed to working with partners at the federal, national, and local levels to disseminate, implement, and evaluate the recommendations in the U. S. Selected Practice Recommendations for Contraceptive Use 2013 (U.S. SPR) so that the information reaches health-care providers. Strategies for dissemination and implementation include collaborating with other federal agencies and professional and service organizations to widely distribute the recommendations through presentations, electronic distribution, newsletters, and other publications; development of provider tools and job aids to assist providers in implementing the new recommendations; and training activities for students, as well as for continuing education. CDC will conduct a survey of family planning health-care providers before and after release of this report to assess attitudes and practices related to contraceptive use. Results from this survey will assist CDC in evaluating the impact of these recommendations on the provision of contraceptives in the United States. Finally, CDC will continually monitor new scientific evidence and will update these recommendations as warranted by new evidence. Updates to the recommendations, as well as provider tools and other resources, are available on the CDC U.S. SPR Web site .

Implementation Tools

Clinical Algorithm

Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. U.S. selected practice recommendations for contraceptive use, 2013: adapted from the World Health Organization selected practice recommendations for contraceptive use, 2nd edition. MMWR Recomm Rep. 2013 Jun 21;62(RR-05):1-60. PubMed

Adaptation

The Centers for Disease Control and Prevention (CDC) initiated a formal adaption process to create the U.S. selected practice recommendation for contraceptive use, 2013 (U.S. SPR), using the following documents as the basis for their adapted recommendations:

- World Health Organization. Selected practice recommendations for contraceptive use. Second ed. Geneva: World Health Organization; 2004.
- World Health Organization. Selected practice recommendations for contraceptive use. 2008 update. Geneva, Switzerland: World Health Organization; 2008. Available at http://whqlibdoc.who.int/hq/2008/WHO_RHR_08.17_eng.pdf.

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Guideline Committee

Centers for Disease Control and Prevention Steering Committee

Composition of Group That Authored the Guideline

Centers for Disease Control and Prevention (CDC) Steering Committee: Kathryn M. Curtis, PhD (*Chair*); Denise J. Jamieson, MD; Polly A. Marchbanks, PhD; Naomi K. Tepper, MD; CDC, Atlanta, Georgia

Financial Disclosures/Conflicts of Interest

The Centers for Disease Control and Prevention (CDC), its planners, and its content experts wish to disclose it has no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. Planners have reviewed content to ensure there is no bias.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site.

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

Availability of Companion Documents

The following are available:

- Brahmi D, Curtis KM. When can a woman start combined hormonal contraceptives (CHCs)?: A systematic review. Contraception. 2013;87(5):524-38.
- Cleary TP, Tepper NK, Cwiak C, Whiteman MK, Jamieson DJ, Marchbanks PA, Curtis KM. Pregnancies after hysteroscopic sterilization: a systematic review. Contraception. 2013;87(5):539-48.
- Godfrey EM, Folger SG, Jeng G, Jamieson DJ, Curtis KM. Treatment of bleeding irregularities in women with copper-containing IUDs: a systematic review. Contraception. 2013;87(5):549-66.
- Godfrey EM, Whiteman MK, Curtis KM. Treatment of unscheduled bleeding in women using extended or continuous use combined hormonal contraception: a systematic review. Contraception. 2013;87(5):567-75.
- Kapp N, Gaffield ME. Initiation of progestogen-only injectables on different days of the menstrual cycle and its effect on contraceptive effectiveness and compliance: a systematic review. Contraception. 2013;87(5):576-82.
- Rodriguez MI, Godfrey EM, Warden M, Curtis KM. Prevention and management of nausea and vomiting with emergency contraception: a systematic review. Contraception 2013;87(5):583-9.
- Rodriguez MI, Curtis KM, Gaffield ME, Jackson E, Kapp N. Advance supply of emergency contraception: a systematic review. Contraception. 2013;87(5):590-601.
- Salcedo J, Rodriguez MI, Curtis KM, Kapp N. When can a woman resume or initiate contraception after taking emergency contraceptive pills? A systematic review. Contraception. 2013;87(5):602-4.
- Steenland MW, Rodriguez MI, Marchbanks PA, Curtis KM. How does the number of oral contraceptive pill packs dispensed or prescribed affect continuation and other measures of consistent and correct use? A systematic review. Contraception. 2013;87(5):605-10.
- Steenland MW, Zapata LB, Brahmi D, Marchbanks PA, Curtis, KM. Appropriate follow-up to detect potential adverse events after initiation of select contraceptive methods: a systematic review. Contraception. 2013;87(5):611-24.
- Steenland MW, Zapata LB, Marchbanks PA, Curtis, KM. The effect of follow-up visits or contacts after contraceptive initiation on method continuation and correct use. Contraception. 2013;87(5):625-30.
- Tepper NK, Curtis KM, Steenland MW, Marchbanks PA. Blood pressure measurement prior to initiating hormonal contraception: a systematic review. Contraception. 2013;87(5):631-8.
- Tepper NK, Steenland MW, Marchbanks PA, Curtis KM. Hemoglobin measurement prior to initiating copper intrauterine devices: a systematic review. Contraception. 2013;87(5):639-44.
- Tepper NK, Steenland MW, Marchbanks PA, Curtis KM. Laboratory screening prior to initiating contraception: a systematic review. Contraception. 2013;87(5):645-9.
- Tepper NK, Curtis KM, Steenland MW, Marchbanks PA. Physical examination prior to initiating hormonal contraception: a systematic review. Contraception. 2013;87(5):650-4.
- Tepper NK, Steenland MW, Gaffield ME, Marchbanks PA, Curtis KM. Retention of intrauterine devices in women who acquire pelvic inflammatory disease: a systematic review. Contraception. 2013;87(5):655-60.
- Tepper NK, Marchbanks PA, Curtis KM. Use of a checklist to rule out pregnancy: a systematic review. Contraception. 2013;87(5):661-5.
- Whiteman MK, Tyler CP, Folger SG, Gaffield ME, Curtis KM. When can a woman have an intrauterine device inserted? A systematic review. Contraception. 2013;87(5):666-73.
- Zapata LB, Steenland MW, Brahmi D, Marchbanks PA, Curtis KM. Patient understanding of oral contraceptive pill instructions related to missed pills: a systematic review. Contraception. 2013;87(5):674-84.
- Zapata LB, Steenland MW, Brahmi D, Marchbanks PA, Curtis KM. Effect of missed combined hormonal contraceptives on contraceptive effectiveness: a systematic review. Contraception. 2013;87(5):685-700.
- Brahmi D, Steenland MW, Renner RM, Gaffield ME, Curtis KM. Pregnancy outcomes with an IUD in situ: a systematic review. Contraception. 2012;85(2):131-9.
- Paulen ME, Curtis KM. When can a woman have repeat progestogen-only injectables--depot medroxyprogesterone acetate or norethisterone enantate? Contraception. 2009;80(4):391-408.
- Abdel-Aleem H, d'Arcangues C, Vogelsong KM, Gülmezoglu AM. Treatment of vaginal bleeding irregularities induced by progestin only contraceptives. Cochrane Database Syst Rev. 2007 Oct 17;(4):CD003449.
- Peterson HB, Cates W, Jr. Evidence-based medicine in action: the United States Selected Practice Recommendations for Contraceptive Use. Editorial. Contraception. 2013;87(5):509-10.
- Curtis KM, Tepper NK, Jamieson DJ, Marchbanks PA. Adaptation of the World Health Organization's Selected Practice Recommendations for Contraceptive Use for use in the United States. Commentary. Contraception. 2013;87(5):513-6.
- Folger SG, Jamieson DJ, Godfrey EM, Zapata LB, Curtis KM. Evidence-based guidance on selected practice recommendations for contraceptive use: identification of research gaps. Commentary. Contraception. 2013;87(5):517-23.

Electronic copies: Available to subscribers from the Conception Journal Web site.

In addition, summary charts and clinical algorithms that summarize the guidance for the various contraceptive methods are available in the original guideline document, including a Summary Chart of *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010* (Appendix A), when to start using specific contraceptive methods (Appendix B), examinations and tests needed before initiating the various contraceptive methods (Appendix C), routine follow-up after initiating contraception (Appendix D), management of bleeding irregularities (Appendix E), and management of intrauterine devices (IUDs) when users are found to have pelvic inflammatory disease (PID) (Appendix F).

A continuing education examination is available from the Centers for Disease Control and Prevention (CDC) Web site.

Additional tools are available on the U.S. Selected Practice Recommendations (SPR) Web site.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on April 18, 2014. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs).

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